Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Lawrence Wald, DC

Respondent Name
New Hampshire Insurance Company

MFDR Tracking Number
M4-15-1038-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
December 1, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "**The enclosed claim was denied in error.** This claim was for a Division-ordered Designated Doctor Exam. The denial states the 'ADDITIONAL PAYMENT MADE ON APPEAL/RECONSIDERATION; PAYMENT DENIED/REDUCED FOR ABSENCE OF PRECERTIFICATION/AUTHORIZATION; NO ADDITIONAL ALLOWANCE HAS BEEN RECOMMENDED'. However, this is incorrect.

With this 2nd Request for Reconsideration, I am including a copy of both of the DWC32s, which show this exam was requested & approved through TDI-DWC – and since this service does not require preauthorization. Initially, the requested exam was to determine MMI (Maximum Medical Improvement) and the IR (Impairment Rating); on February 24, 2014 … the Office of Injured Employee Counsel asked that we add Extent of Injury to the exam. I've attached both the original and the amended DWC-32 forms to this request for reconsideration.

We billed a total of $2,500.00 for these services. We have received no payment from your company. Please issue prompt payment in the amount of **$2,550.00** to settle this claim.

The denial of parts of this claim is in violation of the rules of the Texas Department of Insurance Division of Workers' Compensation as this service was ordered on the DWC-32. Failure to submit payment for this examination is in violation of the rules of the Texas Department of Insurance Division of Workers' Compensation as this service was ordered on the DWC-32."

Amount in Dispute: $1200.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Respondent would show that Requestor is not entitled to additional reimbursement for the services at issue, because it has already been reimbursed to full amount to which it is entitled under the Texas Workers' Compensation Act and Division Rules."

Response Submitted by: Adami, Shuffield, Scheihing & Burns

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 11, 2014	Designated Doctor Examination	$1200.00	$1200.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out the fee guidelines for billing and reimbursing Designated Doctor Examinations.
3. 28 Texas Administrative Code §127.1 sets out the procedures to request Designated Doctor Examinations.
4. 28 Texas Administrative Code §127.5 sets out the procedures for scheduling Designated Doctor Examinations.
5. 28 Texas Administrative Code §127.10 sets out the general procedures for Designated Doctor Examinations.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 197 – Payment denied/reduced for absence of precertification/authorization
   - OA – The amount adjusted is due to bundling or unbundling of services
   - W3 – Additional payment made on appeal/reconsideration
   - 947 – R03 – Upheld – No additional allowance has been recommended.
   - 197 – Recommended allowance based on negotiated discount/rate.

Issues

1. Are the disputed services subject to preauthorization?
2. Are the disputed services subject to bundling rules?
3. What is the correct MAR for the disputed services?
4. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier denied payment for the disputed services stating, "Payment denied/reduced for absence of precertification/authorization." 28 Texas Administrative Code §127.1 sets out the procedures to request Designated Doctor Examinations. Preauthorization is not included in these procedures. The disputed services are for a Designated Doctor Examination. Therefore, the disputed services are not subject to preauthorization.
2. The insurance carrier denied payment for the disputed services stating, "The amount adjusted is due to bundling or unbundling of services." 28 Texas Administrative Code §134.204 sets out the fee guidelines for reimbursing Designated Doctor Examinations. 28 Texas Administrative Code §134.204 does not indicate that the dispute services are bundled with any other services.
3. Per 28 Texas Administrative Code §134.204 (j)(3), "The following applies for billing and reimbursement of an MMI evaluation. (C) An examining doctor, other than the treating doctor, shall bill using CPT Code 99456. Reimbursement shall be $350." The submitted documentation indicates that the Designated Doctor performed an evaluation of Maximum Medical Improvement as ordered by the Division. Therefore, the correct MAR for this examination is $350.00.

   Per 28 Texas Administrative Code §134.204 (j)(4), "The following applies for billing and reimbursement of an IR evaluation. (C)(ii) The MAR for musculoskeletal body areas shall be as follows. (II) If full physical evaluation, with range of motion, is performed: (-a-) $300 for the first musculoskeletal body area." The submitted documentation indicates that the Designated Doctor performed a full physical evaluation with range of motion for the left shoulder to find the Impairment Rating. Therefore, the correct MAR for this examination is $300.00.

   Per 28 Texas Administrative Code §134.204 (k), "The following shall apply to Return to Work (RTW) and/or Evaluation of Medical Care (EMC) Examinations. When conducting a Division or insurance carrier requested RTW/EMC examination, the examining doctor shall bill and be reimbursed using CPT Code 99456 with modifier "RE." In either instance of whether MMI/IR is performed or not, the reimbursement shall be $500 in accordance with subsection (i) of this section and shall include Division-required reports. Testing that is required shall be billed using the appropriate CPT codes and reimbursed in addition to the examination fee." The submitted documentation indicates that the Designated Doctor performed an examination to determine Extent of Injury. Therefore, the correct MAR for this examination is $500.00.

   Per 28 Texas Administrative Code §127.10 (d), "…If a designated doctor is simultaneously requested to address MMI and/or impairment rating and the extent of the compensable injury in a single examination, the designated doctor shall provide multiple certifications of MMI and impairment ratings that take into account each possible outcome for the extent of the injury…If the designated doctor provided multiple certifications of MMI and impairment ratings, the designated doctor must file a Report of Medical Evaluation under §130.1(d) of this title for each impairment rating assigned and a Designated Doctor Examination Data Report pursuant to

§127.220 of this title (relating to the Designated Doctor Reports) for the doctor's extent of injury determination..."

Furthermore, 28 Texas Administrative Code §134.204 (j)(4)(B) states, "When multiple IRs are required as a component of a designated doctor examination … the designated doctor shall bill for the number of body areas rated and be reimbursed $50 for each additional IR calculation. Modifier 'MI' shall be added to the MMI evaluation CPT code." The submitted documentation indicates that the Designated Doctor was ordered to address Maximum Medical Improvement, Impairment Rating, and Extent of Injury. The narrative report and enclosed forms support that these examinations were performed, and multiple impairment ratings were provided appropriately. Therefore, the correct MAR for this service is $50.00.

4. The insurance states in their position statement, "Requestor is not entitled to additional reimbursement for the services at issue, because it has already been reimbursed to full amount to which it is entitled under the Texas Workers' Compensation Act and Division Rules." However, the total allowable for the disputed services is $1200.00, of which the insurance carrier has paid $0.00. Therefore, the requestor is entitled to reimbursement of $1200.00.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $1200.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $1200.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

	Laurie Garnes	March 3, 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.